Section 4

Program Assessment

Section 4. Program Assessment

This section is designed to assess the effectiveness of your SCHIP program(s), including enrollment, disenrollment, expenditures, access to care, and quality of care.

4.1 Who enrolled in your SCHIP program?

Answer by completing the following sections.

4.1.1 What are the characteristics of children enrolled in your SCHIP program? (Section 2108(b)(1)(B)(i))

Please complete Table 4.1.1 for each of your SCHIP programs, based on data from your HCFA Quarterly Enrollment Reports. Summarize the number of children enrolled and their characteristics. Also, discuss average length of enrollment (number of months) and how this varies by characteristics of children and families, as well as across programs.

States are also encouraged to provide additional tables on enrollment by other characteristics, including gender, race, ethnicity, parental employment status, parental marital status, urban/rural location, and immigrant status. Use the same format as Table 4.1.1, if possible.

TABLE 4.1.1 CHARACTERISTICS OF CHILDREN IN KIDSCARE

Table 4.1.1, below, is based on the HCFA Quarterly Enrollment Reports. The table provides information on "number of children ever enrolled", "average number of months of enrollment", and "number of disenrollees". This table reflects a high number of KidsCare enrollees converted to Medicaid.

Table 4.1.1 SCHIP Program Type State-designed SCHIP Program

Characteristics	Number of children Ever enrolled		Average number of months of enrollment[a]		Number of disenrollees	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
All Children	N/A	27,021	N/A	3.44	N/A	10,075
Age						
Under 1	N/A	309	N/A	3.25	N/A	

[a] The "average number of months of enrollment" may be somewhat low and misleading for a couple of reasons. First, it was a start-up year so no one had the full twelve months initial guaranteed enrollment at the time of this report, thus lowering the average somewhat. Secondly, a high number of children were disenrolled from SCHIP because they were later determined eligible for Medicaid. This too had an impact on "the average number of months of enrollment". Table 4.2.3 provides more information on disenrollment.

Table 4.1.1 SCHIP Program Type State-designed SCHIP Program						
Characteristics	**Number of children Ever enrolled**		**Average number of months of enrollment[a]**		**Number of disenrollees**	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
1-5	N/A	6,790	N/A	3.50	N/A	
6-12	N/A	11,350	N/A	4.00	N/A	
13-18	N/A	8,572	N/A	3.00	N/A	
Countable Income Level[b]						
At or below 150% FPL	N/A	27,021	N/A	2	N/A	
Above 150% FPL	N/A	N/A	N/A	N/A	N/A	N/A
Age and Income						
Under 1						
At or below 150% FPL	N/A	309	N/A	2	N/A	
Above 150% FPL	N/A	N/A	N/A	N/A	N/A	N/A
1-5						
At or below 150% FPL	N/A	6,790	N/A	2	N/A	
Above 150% FPL	N/A	N/A	N/A	N/A	N/A	N/A
6-12						
At or below 150% FPL	N/A	11,350	N/A	2	N/A	
Above 150% FPL	N/A	N/A	N/A	N/A	N/A	N/A
13-18						
At or below 150% FPL	N/A	8,572	N/A	2	N/A	
Above 150% FPL	N/A	N/A	N/A	N/A	N/A	N/A
Type of plan						
Fee-for-service	N/A	1,633	N/A	2	N/A	

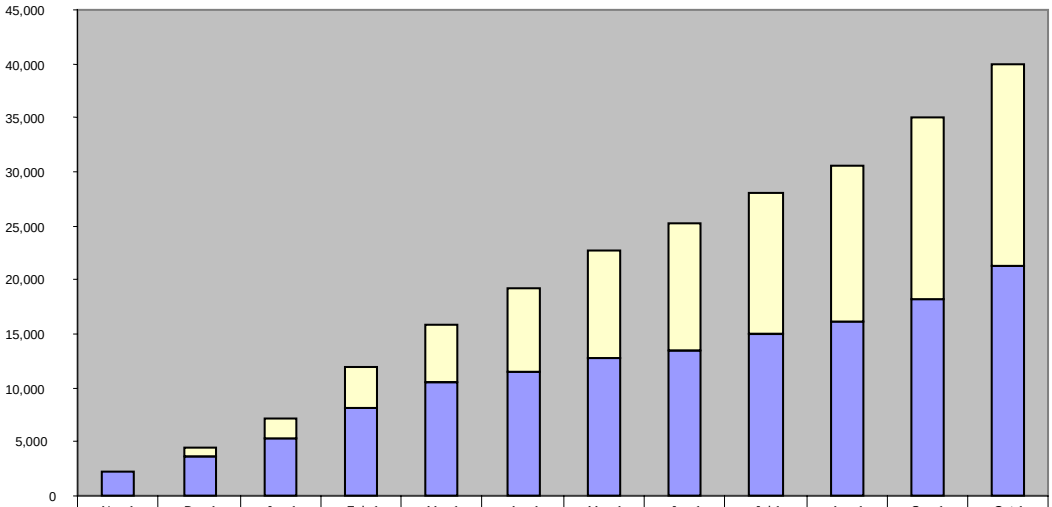
[b] Countable Income Level is as defined by the states for those that impose premiums at defined levels other than 150 percent FPL. See the HCFA Quarterly Report instructions for further details.

Table 4.1.1 SCHIP Program Type State-designed SCHIP Program						
Characteristics	**Number of children Ever enrolled**		**Average number of months of enrollment[a]**		**Number of disenrollees**	
	FFY 1998	FFY 1999	FFY 1998	FFY 1999	FFY 1998	FFY 1999
Managed care*	N/A	25,388	N/A	2	N/A	
PCCM	N/A	N/A	N/A	N/A	N/A	N/A

*Source: HCFA Quarterly Enrollment Reports, Forms HCFA-21E, HCFA-64.21E, HCFA-64EC, HCFA Statistical Information Management System, October 1998.

ADDITIONAL ENROLLMENT INFORMATION & CHARACTERISTICS OF CHILDREN IN KIDSCARE

Enrollment figures are included so that the pie charts can be quickly referenced to enrollment. Pie charts are provided on the age and ethnicity of children in KidsCare.



	Nov 1	Dec 1	Jan 1	Feb 1	Mar 1	Apr 1	May 1	Jun 1	Jul 1	Aug 1	Sep 1	Oct 1
Medicaid		741	1878	3706	5217	7812	9884	11792	13107	14531	16938	18693
Actual KidsCare Only*	2252	3710	5283	8194	10578	11458	12766	13444	14985	16066	18167	21256
Totals	2252	4451	7161	11900	15795	19270	22650	25236	28092	30597	35105	39949

Source: The table is generated from monthly AHCCCS enrollment figures, which are in a point-in-time. Enrollment is for the 1st of each month.

*****It should be noted that KidsCare enrollment includes Direct Services, which accounted for 247 children as of October 1, 1999. Direct Services are funded solely by state monies.

ETHNICITY

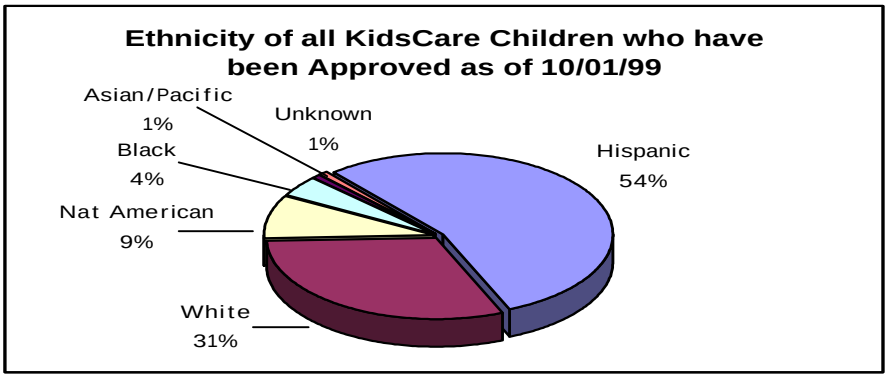


Figure 2 *shows ethnicity of children who have been enrolled in KidsCare.*

AGE

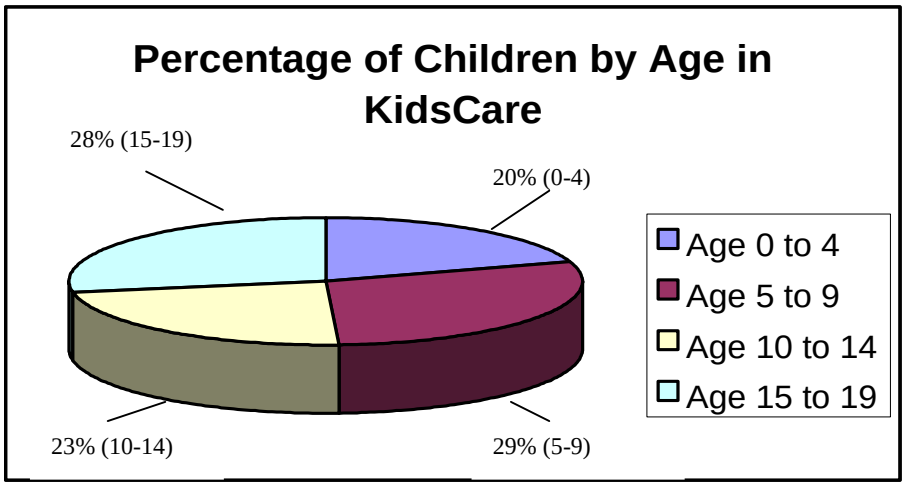


Figure 3 *shows the age break-up of children in KidsCare.*

4.1.2 How many SCHIP enrollees had access to or coverage by health insurance prior to enrollment in SCHIP? Please indicate the source of these data (e.g., application form, survey). (Section 2108(b)(1)(B)(i))

As of October 1, 1999, 668 children or 2.1 percent of the total denials have been because the applicant was covered by group or other insurance. This figure does not include those children who were denied because they already had Title XIX coverage. AHCCCS does not track how many applicants had coverage prior to the required 6 month bare period.

4.1.3 What is the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children? (Section 2108(b)(1)(C))

AHCCCS is able to provide a seamless eligibility process through the use of a simplified dual mail-in application form, which determines eligibility for both KidsCare and Medicaid. As of October 1, 1999, the KidsCare program is responsible for insuring an additional 39,949 children in Arizona. Of this total, KidsCare enrollment was 21,256 children, or 53 percent of this total, while Medicaid accounts for an additional 18,693 children insured, or 47 percent.

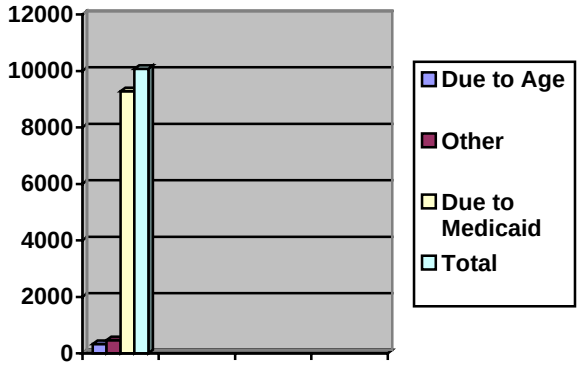
4.2 Who disenrolled from your SCHIP program and why?

Answer by completing the following sections.

4.2.1 How many children disenrolled from your SCHIP program(s)? Please discuss disenrollment rates presented in Table 4.1.1. Was disenrollment higher or lower than expected? How do SCHIP disenrollment rates compare to traditional Medicaid disenrollment rates?

As indicated by Table 4.1.1, 9,282 children, or approximately 92 percent of 10,075 children were disenrolled from KidsCare because of Medicaid eligibility. This figure was much higher than expected. Other than this exception, disenrollment rates for the first year were lower than expected, in part because of the 12 month guaranteed enrollment period, which kept children on the program.

REASONS DISENROLLED



Comparing Title XIX with Title XXI enrollment by using per member, per month enrollment figures shows that from October 1998 through September 1999, 390,722 children were enrolled in Medicaid throughout the year. During the year, 100,590, or 26 percent, of those children disenrolled from Medicaid for various reasons.

In contrast, Title XXI records show that from October 1998 through September 1999, 27,021 were children enrolled in KidsCare throughout the year. During the year, 9,282 children were transferred to Medicaid. Therefore, only 793, or approximately 8 percent, of the SCHIP children disenrolled for various reasons other than Title XIX.

4.2.2 How many children did not re-enroll at renewal? How many of the children who did not re-enroll got other coverage when they left SCHIP?

Since Arizona's KidsCare program was implemented on November 1, 1998, redeterminations are not due until November 1, 1999. Therefore, no data is available.

4.2.3 What were the reasons for discontinuation of coverage under SCHIP? (Please specify data source, methodologies, and reporting period.)

Table 4.2.3

Reason for discontinuation of coverage	Medicaid SCHIP Expansion Program		State-designed SCHIP Program		Other SCHIP Program	
	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total	Number of disenrollees	Percent of total
Total			10,075	100.0		
Access to commercial insurance			47	.46		
Eligible for Medicaid			9,282	92.13		
Income too high			15	.15		
Aged out of program			326	3.24		
Moved/died			38	.38		
Nonpayment of premium			N/A	N/A		
Incomplete documentation			26	.26		
Did not reply/unable to contact			81	.80		
Other #1 Residence			4	.04		
Other #2 Eligibility			100	.99		
Other # 3 Citizenship			80	.79		
Don't know			76	.75		

#1- Other – Residence includes: Residence of an Institution (RI), Resides in Jail (RJ), Not an Arizona Resident

#2-Other – Eligibility includes: Ineligible at time of Approval (TA). Temporarily ineligible (TI), Voluntary Discontinuance (VD), Voluntary Withdrawal (VW), Application taken in error (AE), Discontinued due to a hearing decision (MB)

#3-Other - Citizen – Noncompliance includes: Citizenship / Qualified Alien status not met (CI), or Failed to cooperate with Medicaid requirements (FC).

4.2.4 What steps is your State taking to ensure that children who disenroll, but are still eligible, re-enroll?

The state has developed an authorization form signed by the applicants, which permits the state to notify advocacy groups that their clients have failed to provide some

requested documentation. Advocacy groups plan to work with their clients to ensure they understand and comply with KidsCare redeterminations requirements. This process should be a useful tool once redeterminations begin November 1, 1999.

However, approximately only 1 percent of the discontinuances have been for reasons that could be corrected and result in future eligibility. For example, 9,282 discountenances, or over 92 percent, were because the child was eligible for Title XIX.

4.3 How much did you spend on your SCHIP program?

Answer by completing the following sections.

4.3.1 What were the total expenditures for your SCHIP program in federal fiscal year (FFY) 1998 and 1999?

FFY 1998	N/A
FFY 1999	$11,650,340*

* This total represents total program and administrative expenditures for FFY 1999, excluding those administrative expenditures exceeding the 10 percent limit as specified in 42 U.S.C. 1397ee.

Please complete Table 4.3.1 for each of your SCHIP programs and summarize expenditures by category (total computable expenditures and federal share). What proportion was spent on purchasing private health insurance premiums versus purchasing direct services?

Table 4.3.1 is on the following page.

AHCCCS provides KidsCare coverage through managed care and a small fee-for-service program. Capitation expenditures represent 98 percent, while fee-for-service expenditures represent 2 percent of total program expenditures. Services for Native Americans who go through IHS make up the FFS expenditures. No funds were spent on purchasing private health insurance premiums.

Table 4.3.1 SCHIP Program Type State-designed Program

Type of expenditure	**Total computable share**		**Total federal share**	
	FFY 1998	**FFY 1999**	**FFY 1998**	**FFY 1999**
Total expenditures		$10,485,306		$7,953,104

Table 4.3.1 SCHIP Program Type State-designed Program				
Type of expenditure	**Total computable share**		**Total federal share**	
	FFY 1998	**FFY 1999**	**FFY 1998**	**FFY 1999**
Premiums for private health insurance (net of cost-sharing offsets)*		$10,277,415		$7,795,419
Fee-for-service expenditures (subtotal)		$207,891		$157,685
Inpatient hospital services		$65,114		$49,389
Inpatient mental health facility services		$1,401		$1,063
Nursing care services		$254		$193
Physician and surgical services		$18,640		$14,138
Outpatient hospital services		$23,991		$18,198
Outpatient mental health facility services				
Prescribed drugs		$539		$408
Dental services		$41,920		$31,796
Vision services		$1,414		$1,073
Other practitioners' services		$145		$110
Clinic services		$2,042		$1,549
Therapy and rehabilitation services		$27		$21
Laboratory and radiological services		$5,106		$3,873

* These expenditures are capitation payments to health plans reported on line 1 on the form HCFA 21.

Table 4.3.1 SCHIP Program Type State-designed Program				
Type of expenditure	**Total computable share**		**Total federal share**	
	FFY 1998	**FFY 1999**	**FFY 1998**	**FFY 1999**
Durable Medical Equipment		$5,818		$4,412
Family planning		$9,725		$7,376
Abortions				
Screening services		$6,035		$4,578
Home health				
Home and community-based services				
Hospice				
Medical transportation		$25,708		$19,499
Case management				
Other services		$12		$9

4.3.2 What were the total expenditures that applied to the 10 percent limit? Please complete Table 4.3.2 and summarize expenditures by category.

See Table 4.3.2 on following page.

What types of activities were funded under the 10 percent cap?

The activities were: outreach efforts, including initial consulting and marketing expenditures, staffing for program development and eligibility determinations, automation and information systems, capital expenditures and other general administrative expenditures.

What role did the 10 percent cap have in program design?

AHCCCS has struggled to meet conflicting needs of a new program with a cap of 10 percent for administrative costs. State-designed SCHIP programs had to establish the administrative infrastructure to run the program and reach out to the potential members. Establishing a viable KidsCare program required an investment in administrative staff, facilities, tracking and claiming systems, capacity for eligibility determinations, and comprehensive outreach efforts to spread the word of the KidsCare program. These choices, one of meeting the needs of potential members or staying within a 10 percent administrative cap, are especially hard for a first year, in a stand-alone program, even with the ability to roll costs over a three-year period.

Table 4.3.2						
Type of expenditure	**Medicaid SCHIP Expansion Program**		**State-designed SCHIP Program**		**Other SCHIP Program**	
	FY 1998	FY 1999	FY 1998	FY 1999	FY 1998	FY 1999
Total computable share						
Outreach						
Administration				$1,165,034		
Other_____						
Federal share						
Outreach						
Administration				$883,678		

Note: The amounts reported in Table 4.3.2 represent total administrative expenditures claimed under the 10 percent limit. Actual administrative expenditures incurred are $5,099,494. AHCCCS was able to claim $1,165,034, of which the federal share was $833,678.

4.3.3 What were the non-Federal sources of funds spent on your SCHIP program (Section 2108(b)(1)(B)(vii))

___State appropriations
___ County/local funds
___ Employer contributions
___Foundation grants
___ Private donations (such as United Way, sponsorship)
_x_ Other (specify) Allocation from the Tobacco Tax Fund

Funds for the KidsCare program come from a combination of state funds and federal funds. The state portion is provided from the medically needy account of the Tobacco Tax Fund.

Community Contributions

KidsCare is funded with state and federal funds, and has received contributions from other sources. For example, members of the community have contributed to KidsCare through voluntarism and outreach activities.

Members of the community have volunteered their time to attend community events and health fairs scheduled by the outreach coordinator, where they have distributed KidsCare information and applications.

Since the 10 percent allowed by federal legislation for Administration and Outreach is based on expenditures, there have been limited federal matching funds available for initial outreach efforts.

In addition, AHCCCS has worked closely with the Children's Action Alliance, a nonprofit research, education and advocacy organization for children and families. The Children's Action Alliance is also a Robert Wood Johnson grantee for KidsCare Outreach, called *Covering Kids*. Contributions have also come from the Flinn Foundation, which has funded several activities, including over $100,000 in various grants commissioning studies on the KidsCare program. More recently, the Flinn Foundation has continued its support by funding several grants for KidsCare outreach efforts. Finally but not least, St. Luke's Charitable Health Trust has recently awarded six community organization grants to conduct outreach programs as part of their *Kids Connect* program.

KidsCare has also benefited from major corporate sponsorships that have included: Osco Drugs, Bashas, Hickman's Eggs, Video Update, Domino's Pizza, Diamondbacks, and Arizona Thunder.

4.4 How are you assuring SCHIP enrollees have access to care?

AHCCCS Administration requires all contractors to have sufficient provider capacity to serve the KidsCare program. Currently, all AHCCCS members have a choice of at least two contractors. The AHCCCS Administration assures this in many ways. Some of the key contractual and monitoring activities are:

- Standards for PCP network,
- Standards for appointment standards, and
- Standards for emergency services.

Contractors are required to meet the AHCCCS contractual standards for network capacity for primary care providers (PCPs). The contractor's number of enrolled members to a full-time equivalent PCP can not exceed a ratio of 1:1200 for children 12 and younger and 1:1800 for children over 12. If the PCP contracts with more than one contractor, the ratio is adjusted by the contractor to ensure that the total number of KidsCare and Medicaid members assigned to a PCP does not exceed the above ratio.

Contractors can monitor and ensure that each member is assigned to an individual PCP and that PCP assignment data is current. The contractor monitors the adequacy, accessibility and availability of the provider network and provide encounter data in a form specified by AHCCCS.

In addition, KidsCare enrollees are assured direct access appointment standards for emergency, urgent and routine care, specialty providers, and dentists. Enrollees have direct access to dentists without a referral.

Contractors provide emergency service facilities which are adequately staffed by qualified medical professionals. These facilities are available a 24 hours-per-day, 7 days-per-week basis for treatment of medically emergent conditions. Contractors must educate members about the appropriate utilization of emergency room services and monitor

utilization by both members and providers.

AHCCCS, through operational and financial reviews, monitors contractor compliance with these quality standards.

4.4.1 What processes are being used to monitor and evaluate access to care received by SCHIP enrollees? Please specify each delivery system used (from question 3.2.3) if approaches vary by the delivery system within each program. For example, if an approach is used in managed care, specify 'MCO'. If an approach is used in fee-for-service, specify 'FFS'. If an approach is used in a Primary Care Case Management program, specify 'PCCM.'

Table 4.4.1

Approaches to Monitoring Access	Medicaid SCHIP Expansion Program	State-designed SCHIP Program	Other SCHIP Program*
Appointment audits		MCO	
PCP/enrollee ratios		MCO	
Time/distance standards		MCO	
Urgent/routine care access standards		MCO	
Network capacity reviews (rural providers, safety net providers, specialty mix)		MCO	
Complaint/grievance/ Disenrollment reviews		MCO	
Case file reviews		MCO	
Beneficiary surveys		MCO	
Utilization analysis (emergency room use, preventive care use)		MCO	

* Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

4.4.2 What kind of managed care utilization data are you collecting for each of your SCHIP programs? If your State has no contracts with health plans, skip to section 4.4.3.

Table 4.4.2

Type of utilization data	Medicaid SCHIP Expansion Program	State-designed SCHIP Program	Other SCHIP Program*
Requiring submission of raw encounter data by health plans	___ Yes ___ No	_x_ Yes ___ No	___ Yes ___ No
Requiring submission of aggregate HEDIS data by health plans	___ Yes ___ No	___ Yes _x_ No**	___ Yes ___ No
Other (specify) *N/A*	___ Yes ___ No	___ Yes ___ No	___ Yes ___ No

* Make a separate column for each "other" program identified in section 2.1.1. To add a column to a table, right click on the mouse, select "insert" and choose "column".

** AHCCCS uses HEDIS criteria as a guide.

4.4.3 What information (if any) is currently available on access to care by SCHIP enrollees in your State? Please summarize the results.

Specific data is not available on access to care for KidsCare enrollees in this reporting period due to the program being eleven months old and the lag time to receive all encounters. However, AHCCCS health plans have been very successful in assuring access to care since over 80 percent of the physicians in the state participate in the program. Care is available in a wide range of settings, including Federally Qualified Health Centers and many of the Rural Health Centers who have elected to subcontract with the health plans.

4.4.4 What plans does your SCHIP program have for future monitoring/evaluation of access to care by SCHIP enrollees? When will data be available?

The AHCCCS Administration is working on incorporating encounter data for the SCHIP program into the Quality Improvement Initiative.

Quality of care is a very important component of the AHCCCS program. In its 15 years of operation, AHCCCS has developed a mature quality management system, which focuses on the performance of health plans. Although this approach is effective, AHCCCS, in partnership with the Health Care Financing Administration (HCFA) and the AHCCCS health plans, sought ways to incorporate other innovative elements into the quality management program which were tailored for a managed care environment. A proposal to implement a Quality Management Initiative was approved by HCFA in December 1994 as a multi-year project, which will:

- Develop clinical and long-term care quality management indicators to measure health outcomes and quality of care;

- Use financial indicators for financial performance and solvency standards; and
- Conduct member satisfaction surveys that assess access to care, availability of care and overall member satisfaction.

The AHCCCS Administration plans to have KidsCare population included in this data, which will be submitted per HCFA guidelines.

4.5 How are you measuring the quality of care received by SCHIP enrollees?

The KidsCare Program will use performance measures, quality standards, information strategies and quality improvement studies to assure high quality care for members. The tools will include:

- Quality standards;
- Annual on-site operational and financial reviews;
- Performance indicator and utilization measurement studies;
- Compliance with national quality measures; and
- An independent member survey, which is in the process of being completed for Title XIX and Title XXI populations together.

4.5.1 What processes are you using to monitor and evaluate quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, and immunizations? Please specify the approaches used to monitor quality within each delivery system (from question 3.2.3). For example, if an approach is used in managed care, specify 'MCO'. If an approach is used in fee-for-service, specify 'FFS'. If an approach is used in primary care case management, specify 'PCCM'.

Table 4.5.1

Approaches to monitoring quality	Medicaid SCHIP Expansion Program	State-designed SCHIP Program	Other SCHIP Program
Focused studies (specify)		MCO See below	
Client satisfaction surveys		MCO[a]	
Complaint/grievance/ disenrollment reviews		MCO See below	
Sentinel event reviews			
Plan site visits		MCO See below	
Case file reviews		MCO	

[a] AHCCCS is in the process of completing a survey for both Title XIX and Title XXI members. Information will be sorted by health plans. Results should be available by December 2000.

Table 4.5.1			
Approaches to monitoring quality	**Medicaid SCHIP Expansion Program**	**State-designed SCHIP Program**	**Other SCHIP Program**
Independent peer review		MCO	
HEDIS performance measurement[b]		MCO	
Other performance measurement (specify)		MCO See below	

Performance measurement

AHCCCS has amended its quality review initiative through a State Plan Amendment after this reporting period ended on September 30, 1999. Currently, AHCCCS requires contractors to meet the AHCCCS performance measures, which are defined using HEDIS 3.0 as a guide. In particular, performance measurements will focus on the following areas:

- Age appropriate childhood immunizations;
- Dental visits;
- Well child visits in the first 15 months of life;
- Well child visits in the third, fourth, fifth, and sixth year of life; and
- Access to a regular source of primary care.

Indicator	Summary Description
1. Childhood Immunization Rate	The percent of members under age two who were continuously enrolled for 12 months and received recommended immunizations.
2. Annual Dental Exam	The percent of members age 3-19 with at least one dental visit in the reporting year.
3. Well Child Visits Under 15 Months	The percent of children under the age of 15 months who received all recommended well child visits during the reporting year.
4. Well Child Visits for 3, 4, 5 and 6 Year Olds	The percent of children 3-6 that received a well child visit during the last year.

[b] AHCCCS uses HEDIS criteria as a guide.

Quality standards

Each contractor adheres to specific quality/utilization standards established by the AHCCCS Administration for the KidsCare Program. A comprehensive plan prepared by the contractor includes the following components:

- Program monitoring,
- Program evaluation,
- Member outreach,
- Provider education, and
- Compliance with mandatory components of preventive care visits.

Contractors will participate in an annual review of the KidsCare program, which includes on-site visits by AHCCCS staff to contractors and reviewing the medical record audits.

AHCCCS monitors compliance with quality assurance standards through an established process of operational and financial reviews for the Medicaid program. The reviews are conducted by a review team comprised of AHCCCS staff. The reviews are performed on-site through interviews with appropriate personnel and through review of documentation in the following areas:

- Administration and Management,
- Provider Services/Network Management,
- Grievance and Appeals,
- Medical Management,
- Quality/Utilization Management,
- Dental Services,
- Maternal Health/Family Planning,
- Behavioral Health,
- Delivery System and Access to Care Standards,
- Member Services, and
- Financial.

The review tool contains standards from the review areas identified above and provides the basis for assessing contractor performance, as well as identifying areas where improvements can be made or where there are areas of noteworthy performance and accomplishment.

Information strategies

All contractors are required to inform new members about services within ten days of enrollment. Information includes:

- Benefits of preventive care,
- A complete description of services available,

- How to obtain these services and assistance with scheduling of appointments, and
- A statement that there is no copayment or charge for certain services.

In addition, both eligibility workers and contractors are required to educate KidsCare enrollees about their benefits, rights and responsibilities. This education focuses on the importance of preventive services, such as immunizations, dental visits, health promotion activities and regular visits to their primary care provider instead of using the emergency room for primary care.

Quality improvement strategies

AHCCCS began its Quality Improvement Initiative in 1994. A major goal was to use encounter data to monitor quality and to test new concepts of quality of care that were based on recommendations from the Quality Assurance Reform Initiative (QARI) and HEDIS 3.0 criteria. Strategies to improve quality include the use of performance and financial measures as well as a member survey which will include both Title XIX and Title XXI members.

4.5.2 What information (if any) is currently available on quality of care received by SCHIP enrollees in your State? Please summarize the results.

AHCCCS will have quality data as stipulated by HCFA. However at this time, no data is available. Gathering quality of care data requires twelve continuous months of enrollment and then the encounter data must be gathered and analyzed before results can be made available.

4.5.3 What plans does your SCHIP program have for future monitoring/evaluation of quality of care received by SCHIP enrollees? When will data be available?

A utilization management oversight process will be completed in the summer of 2002 for both KidsCare and Medicaid utilization reports. The project will encompass a comprehensive oversight process to review utilization management of the KidsCare Administration and Medicaid services by the health plans. The primary objective is to ensure the AHCCCS population receives quality of care and that the health plans have an adequate built-in oversight process to avoid under or over-utilization of services by the provider community and that their internal process ensures clean encounter data submission to the AHCCCS Administration.

4.6 Please attach any reports or other documents addressing access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

N/A